STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001148	A. BUILDING _____ B. WING _____	R 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD RIDGE ASSISTED LIVING	**17650 GENERATIONS DR SOUTH BEND, IN 46635**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for the Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 7/10/12. This visit was in conjunction with the Investigation of Complaint IN00113492. Survey date: September 4, 2012 Facility number: 001148 Provider number: 001148 AIM number: N/A Survey team: Janelyn Kulik, RN Census bed type: Residential: 60 Total: 60 Census payor type: Medicaid: 40 Other: 20 Total: 60 Residential Sample: 10 Wood Ridge Assisted Living was found to be in compliance with 410 IAC 16.2 in regard to the Post Survey Revisit to the State Residential Licensure Survey. Quality review completed on September 9, 2012 by Bev Faulkner, RN	{R 000}		